



**TESTIMONY
IN OPPOSITION TO SB 232**

**BEFORE THE
Senate Committee on Health, Human Services,
Insurance and Job Creation**

March 5, 2008

**Mary Klaver
Legislative Legal Counsel
Wisconsin Right to Life**

My name is Mary Klaver and I am the Legislative Legal Counsel for Wisconsin Right to Life. Wisconsin Right to Life opposes Senate Bill 232 because it would jeopardize virtually all of Wisconsin's current laws protecting women and unborn children.

WHY DOES WISCONSIN RIGHT TO LIFE OPPOSE SB 232?

This legislation would seriously jeopardize the constitutionality of virtually all of Wisconsin's laws regulating abortion, including: (1) the prohibition of public funding of abortions, (2) the abortion reporting statute, (3) the parental consent law, (4) the Woman's Right to Know law, (5) the fetal homicide laws, and (6) the Small Employer Health Care Plan with an abortion rider requirement.

This legislation goes well beyond the authors' stated purpose. SB 232 changes the definition of "abortion" contained in each of the above laws in a way that is not only inaccurate, but vague and confusing. The proposed change to the definition of "unborn child" would also create vagueness. Vague laws can be challenged in court and be ruled unconstitutional.

WHAT ARE THE CONSTITUTIONAL CONCERNS REGARDING THE DEFINITIONS IN SB 323?

Laws which regulate abortion are often challenged in court on the ground that they are unconstitutionally vague in an effort to have the court rule that the abortion regulation is unconstitutional. The authors are attempting to unnecessarily and recklessly change various definitions in current laws dealing with abortion in ways that would put those laws in legal peril.

Definition of unborn child. An obvious example of creating unconstitutional vagueness is the proposed change in the definition of "unborn child." Under s. 20.927, which prohibits the public funding of abortion, "unborn child" means "a human being from the time of conception until it is born alive." This definition of "unborn child" *clearly applies to an unborn child located inside the mother* because it uses the term "born alive" which refers to the "complete expulsion or extraction from [the] mother ..." (see s. 990.001 (17) and s. 990.01 (19j) regarding construction of statutes). The proposed change in SB 232 deletes the definition of unborn child and substitutes the term "embryo or fetus" with no indication of where the "embryo or fetus" is located. Consequently, this creates vagueness because the "embryo or fetus" could be located in places other than inside the mother, such as a petri dish used for infertility treatments or embryonic stem cell research.

Definitions of abortion. Supporters of SB 232 apparently fear that the current definitions of abortion in Wisconsin would apply to contraceptives. The fact is the current definitions of abortion in Wisconsin do not include contraceptives. Contraceptives are used to prevent the creation of a new life. Abortion, on the other

hand, terminates the life of an unborn child in the mother's womb. Yet, SB 232 incorrectly assumes that the current definitions of abortion in Wisconsin could be interpreted to include contraceptives.

The authors are overlooking the *current language and context* of the definitions of abortion which *clearly exclude contraceptives*. For example, the phrases "after implantation of a fertilized ovum" in s. 48.375 (2) (a), the parental consent law, and "a woman known by the physician to be pregnant" in s. 69.01 (13m), the abortion reporting law, *clearly exclude contraceptives* which do not work after implantation or when the woman is already known to be pregnant. For the fetal homicide law exclusions in s. 939.75, one merely needs to look at the context. The fetal homicide laws expressly do not apply to contraceptives (see the attached copy of s. 939.75 (2) (b) 4.).

The definition of abortion in the Woman's Right to Know Law (s. 253.10 (2) (a)) was interpreted by a federal court in *Karlin v. Foust*, 975 F.Supp. 1177 (W.D.Wis 1997), to "not apply to the administration of emergency contraception." If the definition does not apply to emergency contraception, then it certainly does not apply to any contraceptive. The *Karlin* interpretation of this definition also applies to the definition of abortion in s. 40.98 (1) (ag), the Small Employer Health Care Plan, because it uses the same definition and this law was enacted after the *Karlin* ruling.

CONCLUSION

SB 232 would interfere with 30 years of laws enacted by the Wisconsin legislature to regulate abortion which are successfully working to protect women and unborn children! Senate Bill 232 would subject the abortion laws in Wisconsin to court challenges claiming they are unconstitutionally vague.

Wisconsin Right to Life urges you to OPPOSE SB 232. Thank you.

DEFINITIONS FOR AND EXCLUSIONS TO THE FETAL HOMICIDE LAWS

939.75 Death or harm to an unborn child. (1) In this section and ss. 939.24 (1), 939.25 (1), 940.01 (1) (b), 940.02 (1m), 940.05 (2g) and (2h), 940.06 (2), 940.08 (2), 940.09 (1) (c) to (e) and (1g) (c), (cm), and (d), 940.10 (2), 940.195, 940.23 (1) (b) and (2) (b), 940.24 (2) and 940.25 (1) (c) to (e), "unborn child" means any individual of the human species from fertilization until birth that is gestating inside a woman.

(2) (a) In this subsection, "induced abortion" means the use of any instrument, medicine, drug or other substance or device in a medical procedure with the intent to terminate the pregnancy of a woman and with an intent other than to increase the probability of a live birth, to preserve the life or health of the infant after live birth or to remove a dead fetus.

(b) Sections 940.01 (1) (b), 940.02 (1m), 940.05 (2g) and (2h),
940.06 (2), 940.08 (2), 940.09 (1) (c) to (e) and (1g) (c), (cm), and
(d), 940.10 (2), 940.195, 940.23 (1) (b) and (2) (b), 940.24 (2) and
940.25 (1) (c) to (e) **do not apply to any of the following:**

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Fetal Homicide

Laws

1. An act committed during an induced abortion. This subdivision does not limit the applicability of ss. 940.04, 940.13, 940.15 and 940.16 to an induced abortion.

2. An act that is committed in accordance with the usual and customary standards of medical practice during diagnostic testing or therapeutic treatment performed by, or under the supervision of, a physician licensed under ch. 448.

2h. An act by any health care provider, as defined in s. 155.01 (7), that is in accordance with a pregnant woman's power of attorney for health care instrument under ch. 155 or in accordance with a decision of a health care agent who is acting under a pregnant woman's power of attorney for health care instrument under ch. 155.

3. An act by a woman who is pregnant with an unborn child that results in the death of or great bodily harm, substantial bodily harm or bodily harm to that unborn child.

4. The prescription, dispensation or administration by any person lawfully authorized to do so and the use by a woman of any medicine, drug or device that is used as a method of birth control or is intended to prevent pregnancy.

(3) When the existence of an exception under sub. (2) has been placed in issue by the trial evidence, the state must prove beyond a reasonable doubt that the facts constituting the exception do not exist in order to sustain a finding of guilt under s. 940.01 (1) (b), 940.02 (1m), 940.05 (2g), 940.06 (2), 940.08 (2), 940.09 (1) (c) to (e) or (1g) (c), (cm), or (d), 940.10 (2), 940.195, 940.23 (1) (b) or (2) (b), 940.24 (2) or 940.25 (1) (c) to (e).



WISCONSIN STATE ASSEMBLY
Christine Sinicki
STATE REPRESENTATIVE

Public Testimony on Senate Bill 232

Senate Committee on Health, Human Services, Insurance, and Job Creation
March 5, 2008

Honorable Chairman Erpenbach and Esteemed Members:

Thank you for hearing Senate Bill 232, the Birth Control Protection Act, and giving me the opportunity to share with you my support of this important legislation. Senate Bill 232 is very straightforward. It guarantees you access to your legally prescribed contraceptives.

This bill was authored in response to numerous complaints from women across the state detailing the alarming trend of being denied their valid FDA approved, physician prescribed birth control. In one case a woman was verbally abused. In another a pharmacist denied a woman birth control then refused to transfer the valid prescription. These situations are simply unacceptable and illustrate the dire need for legal clarity in this area.

Once again, we felt compelled to introduce the Birth Control Protection Act in order to clarify the legal duty of a Pharmacist to fill valid prescriptions regardless of their personal religious beliefs. Pharmacists who choose to deny prescribed contraception because of their personal beliefs are behaving in an inappropriate and unprofessional manor – they should not be rewarded with legal impunity. They should be punished for violating the individual's doctor-patient relationship and privacy rights. No woman should be subjected to the humiliation, stress and hassle of being denied her safe, legal prescriptions at the pharmacy counter.

In recent years we have seen anti-birth control special interest groups spread misinformation about the peer-reviewed scientific literature relating to contraception. Some groups overtly lie to women, telling them that birth control pills cause an abortion. They supported legislation that attempted to define abortion as including birth control pills. Birth control is not abortion. Contraception prevents pregnancy it does not end it.

The Birth Control Protection Act is supported by the Department of Regulations and Licensing, the Medical Examining Board, the Wisconsin Public Health Association, the Wisconsin Association of Local Health Departments and Boards and the Wisconsin Pharmacy Examining board. The FDA, scientific community and the vast majority of the public at large are in agreement here and the legislature should be too.

Again, thank you for your time Chairman Erpenbach and Members. I would be happy to answer any questions you may have.

Carol Van Hulle
Testimony Submitted to Senate Committee on Health March 5, 2008
Support for SB 232

Hi, my name is Carol Van Hulle and I live in Madison.

I'm here today because I feel very strongly about this issue. Specifically, I'm concerned about the notion that people should get to pick and choose which parts of their job they decide to perform. It is not up to individual pharmacists to decide who deserves to have their prescription filled and who doesn't. Should a Catholic pharmacist be able to deny medication to couples seeking assisted reproduction? Or a scientologist refuse to fill a prescription for Prozac because he doesn't believe in psychiatric disorders. Should a pharmacist refuse to fill prescriptions for an AIDS patient because they think homosexual lifestyle is wrong? Part of living and working in a pluralistic society like ours is interacting everyday with people whose beliefs are different than our own, or whose behavior we may not always approve of.

Birth control, like any other medication, is prescribed for a variety of purposes and is a part of many women's basic health care. This bill, SB 232, sends a strong message that women of Wisconsin who use birth control have as much right to have their prescriptions filled, when and where they choose, as you or me or anyone else seeking medical care.

Please support Senate Bill 232 – the Birth Control Protection Act

Thank you for your time.

STATEMENT OF R. ALTA CHARO IN SUPPORT OF SB 232

Thank you for the opportunity to testify in support of SB 232. My name is Alta Charo and I am the Warren P. Knowles Professor of Law and Bioethics at the University of Wisconsin Law and Medical Schools. From 1996 to 2001, I was a presidential appointee to the National Bioethics Advisory Commission.

I have written at length on the issue of “conscious refusals” by medical professionals. Attached to this statement is an article I wrote in 2007 entitled “Health Care Provider Refusals to Treat, Prescribe, Refer and Inform: Professionalism and Conscience” which was published by the American Constitution Society.

There are many documented instances throughout the country of pharmacists refusing to fill contraception prescriptions. Perhaps the best known occurred in Wisconsin, when Neil Noesen refused to fill or even transfer a patient’s prescription.

Contraception is part of a comprehensive approach to women’s health. For some women, pregnancy can be dangerous, due to underlying medical conditions that could be worsened. For others, it is needed to space the births of their babies, and thus enhance the probabilities of healthy outcomes for their children. And even for those for whom it is, as many call it, a “lifestyle choice,” contraception is basic health care for women. It does not destroy an embryo or fetus. Contraception is necessary to avoid unintended or unwanted pregnancies that can either result in the need to seek out an abortion or the birth of a baby under less than optimal circumstances for either mother or child. To thwart a patient’s considered choice and a physician’s medical judgment on the basis of “conscience” is to undermine not only patient autonomy but patient health.

Patients exist in a world in which it is not easy to see a doctor, get a prescription, and have the prescription filled. Any barrier to receiving a prescription is a burden and a source of delay while the patient hunts, perhaps fruitlessly, for another pharmacy or another pharmacist or even (if as in the Noesen case, the prescription is held hostage) for another physician appointment. Contraceptives are time-sensitive medications, which must be taken faithfully, often daily, to be effective. Delaying even a single day and missing even a single dose can mean an entire month’s loss of protection against unintended, unwanted or unsafe pregnancy.

The Wisconsin Administrative Code (Phar. 10.03) defines unprofessional conduct as “engaging in any pharmacy practice which constitutes a danger to the health, welfare, or safety of patient or public. . .” A pharmacist’s commitment to refrain from endangering a patient’s health, welfare or safety is unconditional. There is no exception that allows a pharmacist to endanger a patient’s health in the name of his or her own personal or religious beliefs.

S.B. 232 reinforces existing Wisconsin law, which precisely defines pharmacists’ authority. Wis. Stat. § 450.01(16) describes the scope of pharmacy practice to include such integral duties as interpreting prescription orders, providing information on drugs and devices, making therapeutic alternate drug selections and conducting drug regimen screenings. All of these duties

reflect the important role that pharmacists play in our health care delivery system. This bill in no way limits a pharmacist's ability to assess and refuse to fill a prescription based on his or her *professional* concerns, as is clearly set forth in these statutes.

Nowhere in current Wisconsin statutes, however, a pharmacist given authority to refuse to dispense a drug because of a personal, as opposed to a medical, concern about the prescription. As specifically provided in Wisconsin statutes, the pharmacist is limited to looking for contraindications or drug-drug interactions, and bringing such information to the attention of patient and physician. It is never appropriate for pharmacists to wholly override the physician/patient decision as to the ethical course of treatment.

The reason pharmacists, and other health professionals, are asked to sacrifice some of their own personal autonomy, is that they are licensed by the State of Wisconsin to provide professional services to patients. Licensed pharmacists are, in essence, given a state-authorized monopoly on filling prescriptions. As a state-authorized monopoly, their profession is somewhat akin to a public utility. The pharmacist is no more entitled to discriminate against women who engage in sexual activity without reproductive intent than is the power company executive entitled to deny services to the local neo-Nazi clubhouse, or a police officer to refuse protection to the local gambling establishment [See *Endres v. Indiana State Police*, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004))]. As members of a state-created monopoly, and as a condition of receiving their state licenses, pharmacists take on an obligation to serve the general public in a non-discriminatory fashion.

This bill is consistent with Wisconsin law that already enshrines the obligation to provide services in a non-discriminatory fashion. The Wisconsin Administrative Code's Rules of the Pharmacy Examining Board, Section 10.03(9), defines "refusing to render professional services to a person because of race, color, sex, religion, or age" as unprofessional conduct.

Oral contraceptives are taken exclusively by women. Only women are directly affected by this pattern of service refusals. The refusals are intended to interfere with their reproductive choices, an area of life accorded special protection under constitutional law. And while constitutional protections focus on issues surrounding state action, even in a commercial context it is worth noticing that these refusals are aimed almost exclusively at the intersection of these two areas marked by the courts for special concern: women and their sexual or reproductive choices.

One might ask whether the current debate over refusal clauses would sound any different if it were more baldly framed as the asserted right of pharmacists to refuse service to "bad women."

Pharmacists may not pick and choose which patients to serve based on personal bias or belief; nor may they substitute their own belief systems for the federal and state laws that make these medications a legal and protected option for women. Not only is non-discrimination a requirement of existing Wisconsin law, it is an ethical obligation, as enshrined in the code of the American Pharmacists' Association ("APhA"), which calls for the pharmacist to "respect the autonomy and dignity of each patient." The APhA's 1997-98 Policy Committee Report notes that the primary obligation of the pharmacist is to care for the patient. The report states, "Pharmacists ... have a responsibility to the patient.... [T]he patient should not be required to

abide by the pharmacist's personal, moral decision."

When a pharmacist refuses to fill a valid, safe prescription for birth control, the patient-centered orientation of the practice is sacrificed to the pharmacist's own personal, non-professional, often religiously-based beliefs. Patient autonomy is undermined, patient rights are abridged and patient health and welfare is jeopardized.

SB 232 ensures that patients receive the health care they need and that the state licenses pharmacists to provide. There are some health care professionals, including some pharmacists, who believe that their "conscience" is the ultimate consideration, trumping the patient's right or any other right for that matter. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, "of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience." (C. S. Lewis, *God in the dock: essays on theology and ethics*, 292 (Walter Hooper ed., B. Eerdmans Publishing Co., 99) (1970).

Thank you.

Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience

R. Alta Charo*

I. INTRODUCTION

A woman who has been raped is refused emergency contraception by a pharmacist. Another who wants a child is refused fertility services by a physician because she is gay. Another is refused a prescription for a drug needed for the aftermath of a miscarriage, because the pharmacist thinks it may be used for an abortion. A physician refuses to forward medical records for a patient who had an abortion after the fetus was diagnosed with severe deformities. Another physician refuses to perform a routine physical as part of an adoption procedure, because the woman is single.¹

Largely as artifacts of the abortion wars, almost every state has some form of a “conscience clause” on its books—laws that seek to balance a health care provider’s conscientious objection to performing an abortion with the profession’s obligation to afford all patients nondiscriminatory access to services. Traditionally, these laws referred to physician obligations to provide abortion services and, in most cases, the provision of a referral satisfied one’s professional obligations. But in recent years, with the abortion debate increasingly at the center of wider discussions about contraception, end of life care, assisted suicide, genetic screening, reproductive technologies, and embryonic stem-cell research, nurses and pharmacists have begun demanding the same right of refusal. Even more expansively, some professionals are claiming that even a referral or the provision of information makes one complicit in the objectionable act, and therefore are asserting a much broader freedom to avoid facilitating a patient’s health care needs.

The debate surrounding health care provider (“HCP”) right of conscience has emerged with fresh force in the last few years, embedded in a larger national debate about the role of religion in public and professional lives. This debate, which ranges from displays of religious symbols on public property to public acts of religious conviction during public events, is implicated in the discussion of private acts of personal religious conviction in the course of providing professional services to the general public.

This paper describes early refusal clauses and more recent efforts to expand them to allow more HCPs to refuse to provide more kinds of services, as well as some legislative and regulatory actions pushing back in the other direction by limiting pharmacist refusals to fill prescriptions. The ethical arguments for provider refusals to

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¹ Rob Stein, *Seeking Care, and Refused*, WASH. POST, July 16, 2006, at A06.

perform services are briefly summarized, along with rejoinders to them. The paper then discusses in more detail the duty of professionals to provide services, based on the prevailing medical ethic of universal care, the principle of non-discrimination, and other considerations. Finally, several policy options are suggested, such as treating health care providers as public accommodations that may not discriminate based on sex, and requiring refusing providers to facilitate the referral of patients to other providers to ensure that every member of the public has access to needed products and services.

II. REFUSAL LAWS FOR ABORTION

Shortly after the U.S. Supreme Court's decision in *Roe v. Wade* in 1973, Congress passed legislation to protect institutions' ability to refuse to offer abortion services.² The federal abortion conscience clause, called the Church Amendment, amended the Public Health and Welfare Act and protects federally funded individuals and entities that refuse to provide sterilization or abortion services when those individuals and entities declare the services to be "contrary to [their] religious beliefs or moral convictions."³ The protection takes two forms—institutions may not be denied eligibility for federal grants, and they are prohibited from taking action against personnel because of their participation, nonparticipation or beliefs about abortion and sterilization. The Church Amendment concerned provision of services only, and did not address refusals to make referrals or to provide information about legal options for care, as part of the informed consent process. Forty-five states followed suit and passed laws to allow certain healthcare providers to refuse to provide abortion services. According to the Guttmacher Institute:

Almost every state in the country also has decades-old policies allowing individual health care providers to refuse to participate in abortion; many of these laws also apply to sterilization, and in 10 states, to contraception more broadly... Only a handful of these laws specifically provide an exception to refusal rights in emergency circumstances; most do not require health care providers to notify their employers if they intend to opt-out of certain services, and only three require any notice to patients; and about a dozen go so far as to allow providers to refuse to provide information, despite the broadly recognized obligations around obtaining patients' informed consent.⁴

In recent years, Congress has again demonstrated interest in facilitating HCP refusals to provide health care that, in the HCP's individual judgment, is contrary to religious or personal conviction. For example, Congress passed the Weldon Amendment, prohibiting state and local authorities from "discriminating" against any health care entity that will not "pay for, provide coverage for or refer for abortions." It also allows a hospital to refuse care to a woman who is in need of an emergency abortion, even if

² Rachel Benson Gold & Adam Sonfield, *Refusing to Participate in Health Care: A Continuing Debate*, GUTTMACHER REP. ON PUB. POL'Y, 8 (Feb. 2000).

³ 42 U.S.C. § 300a-7 (2000).

⁴ Adam Sonfield, *Rights vs. Responsibilities: Professional Standards and Provider Refusals*, GUTTMACHER REP. ON PUB. POL'Y, 7 (Aug. 2005).

the state law requires abortion coverage in such an emergency situation.⁵ Another effort, in the 109th Congress, was jointly sponsored by Senators Kerry and Santorum. Entitled the Workplace Religious Freedom Act of 2005, the bill went beyond the issue of abortion-related refusals, and would have required employers to accommodate employees who refuse to provide a wide range of health care services due to religious objection, albeit with a requirement that alternate arrangements be made available for the patient to receive the requested services.

III. EXPANDING ALONG FOUR AXES: RANGE OF PROVIDERS, RANGE OF PROCEDURES, RANGE OF REFUSALS, RANGE OF PROTECTIONS

While conscience clauses originated with an emphasis on physicians, recent legislative efforts have broadened to include pharmacists, nurses or even all persons connected with health care delivery. Such efforts would encompass the growing trend toward pharmacist refusals to fill prescriptions for emergency contraception. (Although emergency contraception has recently been made available over-the-counter for adult women, teens still require prescriptions, and thus may continue to encounter pharmacist refusals.) The most expansive bills would also extend refusal privileges to ancillary personnel, theoretically encompassing medical assistants or even orderlies and clerical workers.

In addition, while earlier conscience clauses focused on abortion and sterilization, the newer proposals include other reproductive services, such as traditional contraception, emergency contraception, and IVF or other fertility services. They also include non-reproductive services, such as end of life care (i.e. withholding and withdrawing heroic measures) or any therapy derived from fetal tissue or embryonic stem cell research (including, for example, some childhood vaccinations).

Further, the range of refusals now includes not only a refusal to perform a procedure, but also the refusal to provide a referral, to offer information or counseling on the legality of options that might be elsewhere available, or to do anything that the HCP regards as "participating" in the service in any way.

Finally, protections in some of the newer proposals recite an expansive list of actions that can no longer be taken against professionals who refuse to provide health care services. These protections include immunity from medical or other professional malpractice liability; protection from state licensing board disciplinary action; and protection from employment practices that might put those who assert a right of conscience at a disadvantage in hiring, retention and promotion.

A law passed in Mississippi in 2004 is a good example of the expansive new breed of refusal clause. It allows almost anyone connected with the health care industry—from doctors, nurses and pharmacists to the clerical staff of hospitals, nursing homes and drug stores—to refuse to participate or assist in any type of health care service, including referral and counseling, without liability or consequence.⁶

Similarly, a bill passed by the Wisconsin legislature (albeit vetoed by the Governor) would have permitted health care professionals to abstain from "participating" in any number of activities, with "participating" defined broadly enough to include not only performance of a service, but also counseling patients about their choices or

⁵ Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, §§ 508(a), 508(d)(1)-(2), 118 Stat. 2809, 3163 (2004).

⁶ S.B. 2619, Reg. Sess. (Miss. 2004); Miss. Code Ann. § 41-41-215 (Enacted 1998; Last Amended 1999).

providing referrals to other providers.⁷ The full range of refusal privileges would extend to such situations as emergency contraception for rape victims, in vitro fertilization for infertile couples, managing patients' requests that painful and futile treatments be withheld or withdrawn, and offering therapies developed with the use of fetal tissue or embryonic stem cells. This last provision could mean, for example, that pediatricians—without professional penalty or threat of malpractice claims—could refuse to tell parents about the availability of varicella (chicken pox) and rubella (German measles) vaccine for their children, because it was developed with the use of tissue from aborted fetuses. Indeed, the issue of vaccine origins in fetal tissue research also raised issues of schools and parents conscientiously objecting to provision of medical services.⁸

With respect to pharmacist refusals in particular, Arkansas, Georgia, Mississippi, and South Dakota have passed laws or adopted regulations explicitly allowing a pharmacist the right to refuse to fill prescriptions based on his or her religious, moral, or personal beliefs or protecting a pharmacist from adverse employment action for doing so. None of these legislative or administrative actions requires the pharmacists to serve the patients' interests by other means, such as referrals or prescription transfers to other pharmacies.⁹

But at the same time that proposals to expand the scope of permitted refusals are proliferating, some actions have been taken to limit refusals, especially by pharmacists. Policies by statute, regulation or administrative interpretation in a number of states attempt to ensure that patients have access to legally prescribed medications, often by requiring a pharmacy to meet this need even if an individual pharmacist it employs refuses. Several proposals forbid pharmacists from refusing to refer or transfer prescriptions, verbally abusing patients, and threatening to breach patients' confidentiality. Moreover, the AMA adopted a resolution supporting legislative efforts that require pharmacists and pharmacies to fill valid prescriptions or "provide immediate referral to an appropriate alternative dispensing pharmacy without interference."¹⁰

The North Carolina and Massachusetts pharmacy boards, for example, have issued statements indicating that pharmacists who impede patients' access to prescription medications will be met with disciplinary action under existing state laws and regulations.¹¹ According to the National Women's Law Center, pharmacy boards in Delaware, New York, Oregon and Texas have also issued policies so that when a

⁷ Assemb. B. 207, 2005-2006 Leg. (Wis. 2005) (available at <http://www.legis.state.wi.us/2005/data/AB-207.pdf>).

⁸ See *Vatican Condemns Vaccines Using Fetal Tissues*, Jul. 22, 2005, available at <http://www.cwnews.com/news/viewstory.cfm?recnum=38498> (last visited Feb. 20, 2007); *Medical Cannibals: The Moral Implications of Fetal Tissue Vaccines*, American Life League, available at <http://www.all.org/article.php?id=10169> (last visited Feb. 20, 2007); Louis J. Salome, *Shot Down: Prep School Rejects Rubella Vaccine*, *Catholic Headmaster Cites Link to Abortion*, ATLANTA JOURNAL-CONST., Nov. 20, 1994, at A16.

⁹ Jill Morrison & Gretchen Borchelt, *Don't Take "No" for an Answer, A Guide to Pharmacy Refusal Laws, Policies and Practices*, 5 (2007) (available at <http://nwlc.org/pdf/donttakeno2007.pdf>) (citing Ark. Ann. § 20-16-304 (1973); Ga. Comp. R. & Regs. r. 480-5-.03 (2001); Miss. Ann. § 41-107-1 (2004); S.D. Codified Laws § 36-11-70 (1998)).

¹⁰ Sonfield, *supra* note 4.

¹¹ Morrison & Borchelt, *supra* note 9 (citing Letter from President James T. DeVita, The Commonwealth of Massachusetts Board of Registration in Pharmacy, to Dianne Luby, President/CEO, Planned Parenthood League of Massachusetts, Inc. (May 6, 2004); North Carolina Board of Pharmacy, Pharmacist FAQs: Frequently Asked Questions for Pharmacists on Conscience Clause, available at http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm (last visited Nov. 20, 2006)).

pharmacist refuses to fill a prescription or provide medication, the pharmacy nonetheless ensures delivery of services to the patient.¹²

And state professional licensing boards have on occasion proceeded to discipline their members for failure to provide services. For example, in one of the country's most egregious cases, a Wisconsin pharmacist not only refused to fill a prescription for birth control, but also refused to transfer it to another pharmacy or to return it to the patient, thus leaving her unable to seek services elsewhere. The pharmacist was eventually disciplined by the state licensing board, although the case turned in large part upon his untruthful claims to his employer that he was prepared to provide a full range of services, rather than upon a finding that such actions are impermissible as a matter of professional obligation and the terms of the license to be a pharmacist.¹³

In June 2006, California's Board of Pharmacy went further, and disciplined a pharmacist who both refused to fill a prescription for emergency contraception and refused to enter it into the necessary database for it to be transferred. Based on California state law, the Board of Pharmacy was able to fine the pharmacist \$750, in this case for the refusal to fill the prescription, and not merely (as in Wisconsin) for failing to transfer it.¹⁴

In the realm of state administrative action, the Nevada pharmacy board now limits pharmacist refusals to those based on professional, not religious, reasons. A similar rule is pending in Washington State.¹⁵ And in April 2005 the Governor of Illinois issued an emergency rule that required pharmacists in that state to fill prescriptions for contraception "without delay."¹⁶ Several pharmacists sued the Governor and other state officials, alleging that an administrative rule requiring them to dispense emergency contraception violated their First Amendment rights to freely exercise their religious beliefs, and also Title VII of the Civil Rights Act of 1964, because it required employers

¹² *Id.* (citing Considering Moral and Ethical Objections, Delaware State Board of Pharmacy News (Delaware State Board of Pharmacy, Dover, Del.), Mar. 2006, at 4; Letter from Lawrence H. Mokhiber, Executive Secretary, New York State Board of Pharmacy, to Supervising Pharmacists, Re: Policy Guideline Concerning Matters of Conscience (Nov. 18, 2005), available at <http://www.op.nysed.gov/pharmconscienceguideline.htm>; Oregon Board of Pharmacy, Position Statement: Considering Moral and Ethical Objections (June 7, 2006), available at http://www.oregon.gov/Pharmacy/M_and_E_Objections_6-06.pdf; Texas State Board of Pharmacy, Plan B, available at <http://www.tsbp.state.tx.us/planb.htm> (last visited Dec. 13, 2006)).

¹³ *Wisconsin Judge Upholds Pharmacy Board's Punishment of Pharmacist Who Refused to Refill Oral Contraceptive Prescription*, MEDICAL NEWS TODAY, available at <http://www.medicalnewstoday.com/medicalnews.php?newsid=37525>.

¹⁴ Morrison & Borchelt, *supra* note 9, at 6 (citing *In re Becker-Ellison*, Citation No. CI 2005 31291 (Cal. Bd. of Pharmacy, Dep't of Consumer Affairs, June 30, 2006) (citation and fine) (on file with the National Women's Law Center)).

¹⁵ *Id.* at 4-5 (citing Adopted Regulation of the Nevada State Board of Pharmacy, LCB File No. R036-06 (effective May 4, 2006); Cy Ryan, *Pharmacy Asked to Withhold Judgment*, LAS VEGAS SUN, May 6, 2006, available at <http://www.lasvegassun.com/sunbin/stories/sun/2006/may/06/566613322.html>; Draft Text WAC 246-869-010 Pharmacies' Responsibilities, available at <http://www3.doh.wa.gov/policyreview/> (last visited Dec. 12, 2006)).

In 1997, the pharmacy manager of a California drug store was reprimanded by his employer for refusing to fill a woman's prescription for emergency contraception. The woman, who had medical reasons for preventing pregnancy, did get her prescription filled elsewhere, but she also pressed complaints with the pharmacy management and the licensing officials. The state pharmacy board declined to take action, however, as no state law or regulation at the time required pharmacists to fill the prescriptions presented to them. Brian P. Knestout, *An Essential Prescription*, 22 J. CONTEMP. HEALTH L. & POL'Y 349 (Spring 2006).

¹⁶ Emergency Amendment to 68 Ill. Admin. Code § 1330.91. (enacted as 68 Ill. Admin. Code § 1330.91(j) on August 25, 2005).

to discriminate against them based on their religious beliefs. Although the state officials filed a motion to dismiss, the federal court ruled that the case may proceed to full consideration. Key to the court's decision was the assertion that the Governor's actions were intended to discriminate on the basis of religious affiliation.¹⁷

While not addressing the broader class of health care providers, nor the broader range of services now being refused, in recent years a number of states have passed legislation or issued regulations to ensure that women seeking medications are not disadvantaged by pharmacists who refuse to fill their prescriptions. As of early 2007, five states explicitly require pharmacists or pharmacies to ensure that valid prescriptions are filled: California, Illinois, Massachusetts, Maine, and Nevada. California's law prohibits pharmacist refusals except when the patient can nonetheless receive her services in a timely manner, the employer has been notified in writing, and the employer can make an accommodation without hardship.¹⁸ Maine pharmacy law and regulations restrict pharmacist refusals to professional and medical reasons. Religious or personal convictions do not justify refusals.¹⁹

Despite these changes in state law, refusals continue to be a problem in states without applicable legislation or regulation, even if pharmacy policies require that patients be given service. In Ohio, for example, a woman and her boyfriend requested Plan B, a form of emergency contraception, but the pharmacist "shook his head and laughed," according to the woman. The pharmacist, she reports, told her that he stocked Plan B but would not sell it to her because he believed it to be a form of abortion.²⁰ Wal-Mart, in whose pharmacy this occurred, has a corporate policy to stock Plan B, and allows any Wal-Mart worker who does not feel comfortable dispensing a product to refuse service, but also directs such employees to refer customers to another pharmacist, pharmacy worker or sales associate.²¹

At the federal level, a number of bills have been introduced to limit HCP refusals, at least in the context of pharmacies. For example, Senator Barbara Boxer introduced the Pharmacy Consumer Protection Act of 2005, which would require pharmacies to fill all valid prescriptions in a timely manner. If the medication is not in stock, the pharmacy would be required to order the medication, transfer the prescription or return the prescription to the patient, depending on the patient's preference. Senator Frank Lautenberg introduced the Access to Legal Pharmaceuticals Act of 2005, which would require pharmacies to dispense all valid prescriptions even if their individual pharmacists refuse to participate. The bill also seeks to ensure that pharmacies avoid hiring pharmacists who refuse to return a patient's prescription, refuse to transfer a prescription, subject a patient to humiliation or harassment, or fail to keep a patient's records confidential.²²

¹⁷ *Menges v. Blagojevich*, 451 F. Supp. 2d 992, 999-1002 (C.D. Ill. 2006).

¹⁸ Morrison & Borchelt, *supra* note 9, at 4 (citing CAL. BUS. & PROF. CODE §§ 4314, 4315, 733 (2005)).

¹⁹ *Id.* (citing Me. R. 02-392 ch. 19, § 11 (citing Me. Rev. Stat. Ann. tit. 32 § 13795(2))).

²⁰ Associated Press, *Wal-Mart Pharmacist Denies Couple Morning-after Pill*, Jan. 16, 2007.

²¹ Misti Crane, *Some Still Refuse to Dispense Plan B*, COLUMBUS DISPATCH, Jan. 15, 2007, at 01A.

²² Morrison & Borchelt, *supra* note 9, at 4 (citing Access to Legal Pharmaceuticals Act, S. 809, 109th Cong. (2005) (introduced Apr. 14, 2005, by Sen. Frank Lautenberg); Pharmacy Consumer Protection Act of 2005, S. 778, 109th Cong. (2005) (introduced Apr. 13, 2005, by Sen. Barbara Boxer); An Act to Amend the Public Health Service Act with Respect to the Responsibilities of a Pharmacy When a Pharmacist Employed by the Pharmacy Refuses to Fill a Valid Prescription for a Drug on the Basis of Religious Beliefs or Moral Convictions, and for Other Purposes, H.R. 1539, 109th Cong. (2005) (introduced Apr. 8, 2005, by Rep. Carolyn McCarthy)).

Overall, according to the The Guttmacher Institute, as of 2006:

- 46 states allow individual HCPs to refuse to provide abortion services;
- 43 states allow institutions to refuse to provide abortion services (15 limiting the privilege of refusal to private institutions and one to religiously-affiliated institutions);
- 13 states allow some HCPs to refuse services related to contraception (four of them specifically mentioning pharmacists, and another four with refusal clauses broad enough to encompass pharmacies);
- 9 states allow institutions to refuse to provide services related to contraception (six of them limited to private institutions); and
- 17 states allow some individual HCPs and institutions to refuse to provide sterilization services.²³

IV. ETHICAL ARGUMENTS FOR AND AGAINST THE PERMISSIBILITY OF PROVIDER REFUSALS TO PROVIDE SERVICES

In a 2005 article entitled "Dispensing With Liberty," philosophers Elizabeth Fenton and Loran Lomasky delineate the major lines of traditional argumentation concerning provider refusals on the grounds of religious belief or personal conscience.²⁴ Their conclusion, which paralleled that presented in a 2005 New England Journal of Medicine piece by this author,²⁵ is that traditional arguments are undermined by their primary focus on a contest between the moral claims of individual patients and providers. Both articles conclude that attention to the power imbalance between the parties, and the special obligations placed upon professionals as a group due to their privileged, quasi-monopoly status as health care providers, form the basis for what is arguably a collective obligation of the profession to provide non-discriminatory access to all lawful services.

Fenton and Lomasky begin by noting that "obligations to perform typically have to meet a higher burden of justification than do obligations to desist."²⁶ In other words, an analysis of traditional arguments about the conflict between individual providers and individual patients must begin with the acknowledgment that an obligation to perform an act requires more justification than a mere obligation to avoid thwarting someone else's actions. And it is true that the law rarely requires individuals to rescue or otherwise take action on behalf of another, absent special justification, such as having put the other person in danger or having previously taken on custodial or other responsibilities that engender a special duty of care.

Following this line of analysis, one can argue that failure to perform a service, whether performing an abortion, filling a contraceptive prescription, or informing a parent of the timeliness of a childhood varicella vaccine, simply constitutes a refusal to act, and that forcing a professional to act in such circumstances requires a high level of justification. As Fenton and Lomasky argue, "By refusing to enter into a

²³ Guttmacher Institute, *State Policies in Brief: Refusing to Provide Health Services*, Feb. 1, 2007, available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (last visited Feb. 27, 2007); National Conference of State Legislatures, *Pharmacist Conscience Clauses: Laws and Legislation*, Oct. 2006, available at <http://www.ncsl.org/programs/health/ConscienceClauses.htm> (last visited Feb. 27, 2007).

²⁴ Elizabeth Fenton & Loren Lomasky, *Dispensing with Liberty: Conscientious Refusal and the "Morning After Pill,"* 30 J. Med. & Phil 579 (2005).

²⁵ R. Alta Charo, *The Celestial Fire of Conscience*, 352 NEW ENGLAND J. MED. 2471 (2005).

²⁶ Fenton & Lomasky, *supra* note 24, at 581.

transaction that the other party desires, one thereby *fails to provide a benefit* but not to *inflict a liability*. If that were not so, then anyone who turns down an offer from a prospective buyer, seller, employer, or suitor is guilty of inflicting a harm on the disappointed party. This would be to expand the notion of harm beyond usability.²⁷

Responses to this argument are several-fold. First, it clearly separates out the calls for right to conscience that encompass forcibly imposing unwanted medical interventions, such as ventilators or feeding tubes, on competent patients who have refused further treatment. Given the recent bills attempting to extend refusal clauses to a refusal to abide by patient wishes in this regard, it is important to note that in this case, at least, it is a provider's actions, not inactions, that are at issue. And of course, such actions would also constitute a common-law battery. Further, state legislation protecting HCPs who inflict such unwanted care on competent patients would run afoul of constitutional protections for patient autonomy.

Second, and perhaps most interestingly, it is suggestive of an as-yet undiscussed aspect of the refusal clause debate. Specifically, the so-called "right of conscience" may be far easier to defend in the case of the non-professional than in the case of the professional. A clothing store salesperson who refuses to assist a single woman shopping for maternity clothes may indeed be leaving her no better or worse off than before she entered the store, and be under no ethical duty to do more than this. But where an affirmative duty to provide a service does exist, then failure to act is not merely nonfeasance, but rather is an active form of misfeasance. Thus, refusal by a licensed taxi driver to pick up an African-American man is more than nonfeasance; due to legal obligations to provide non-discriminatory service, this failure to act is a form of active misfeasance.

Thus, whether the refusal to provide a service should be regarded as mere nonfeasance or as a more serious problem of misfeasance turns, somewhat tautologically, on whether there is a duty to provide service. But on this, there is indeed some guidance, as the statements of the relevant professional societies suggest that just such a duty does indeed exist:

"The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care." —*World Medical Association, Declaration on the Rights of the Patient*

"The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." —*American Medical Association*

"Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse....the nurse is justified in refusing to participate on moral grounds....The nurse is obliged to provide for the patient's safety, to avoid patient abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient." —*American Nurses Association, Code of Ethics*

²⁷ *Id* at 583 (emphasis in original).

"A [physician assistant] has an ethical duty to offer each patient the full range of information on relevant options for their health care. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer an established patient to another qualified provider. PAs are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them."—*American Academy of Physician Assistants, Guidelines for Ethical Conduct for the Physician Assistant Profession*

"[P]harmacists [should] be allowed to excuse themselves from dispensing situations which they find morally objectionable, but that removal from participation must be accompanied by responsibility to the patient and performance of certain professional duties which accompany the refusal....ensuring that the patient will be referred to another pharmacist or be channeled into another available health system...."—*American Pharmacists Association, 1997-98 policy committee report on pharmacist refusal clause*

"Pediatricians should not impose their values on the decision-making process and should be prepared to support the adolescent in her decision or refer her to a physician who can.... Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals."—*American Academy of Pediatrics, position statement on counseling the adolescent about pregnancy options*

"Nurses have the right, under responsible procedures, to refuse to assist in the performance of abortion and/or sterilization procedures.... Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situations ... to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referral ... [And] to inform their employers, at the time of employment, of any attitudes and beliefs that may interfere with essential job functions."—*Association of Women's Health, Obstetric and Neonatal Nurses, position statement on nurses' rights and responsibilities related to abortion and sterilization*

By failing to abide by the standards set by their own professions, those practicing refusal without informing patients of their options and providing referrals or other alternatives are not merely denying a discretionary benefit to the consumer but rather are affirmatively violating a duty to their patients.

A rejoinder might be that these professional standards are wrongheaded, because they deny to HCPs the opportunity to avoid being transformed into mere purveyors of goods and services. The essence of professionalism, the argument goes, involves discretion and judgment, which is why the physician ought to have more authority over

patient choices than a candy seller has over consumer purchases. To do otherwise is to render medical services no different than gumballs. As Fenton and Lomasky present this argument:

"Just as physicians or lawyers or accountants enjoy a liberty to decline to transact with those who seek their services, so too do pharmacists.... [O]ther professionals also turn down potential clients with whom they feel uncomfortable working either for moral or other reasons. It is not inconsistent with professional practice to limit one's clientele. Indeed, just the reverse; one attribute of professionalism is an entitlement to employ one's own judgment concerning which associations to enter."²⁸

Two responses to this argument are in order. First, in the context of health care, refusals have most traditionally been based on medical inappropriateness. That is, an internist can refuse to do surgeries due to lack of qualification or a pediatrician can refuse to provide a drug to a teenager because its risks are poorly understood in younger patients. Refusals based on moral disapprobation, however, are not typical of medical ethics. Thus, the physician is trained to heal the criminal, regardless of personal feelings about the criminal's moral culpability, and leaves to the criminal justice system the task of working to ensure that the now-healed criminal will not use his good health to engage in further criminal acts. This is as true of the thief shot by the homeowner as it is of the battering spouse who presents for repair of his broken knuckles. Even knowing that the act of healing may result in further abusive and criminal acts does not yield a medical ethic that calls for refusing care lest one become complicit in those acts. Instead, the prevailing medical ethic is one of universal *caré*.

Second, the choice of refusals follows a pattern that suggests a discriminatory effect, whether direct or indirect. The argument from complicity, that is, the argument that one ought not be forced to become complicit in an immoral act, is not frequently raised in the context of setting the broken hand bones of the wife-beating husband who might then batter again. Instead, it is raised most frequently in the context of refusing to be complicit with acts that form families with single or gay mothers or with acts that prevent conception or gestation of a child. These are settings in which the parties most frequently affected are women. And while the recent expansion of refusal clause legislation to include a competent patient's request to withhold or withdraw unwanted heroic measures, and the occasional report of refusals to fill erectile dysfunction prescriptions for single or gay men may ultimately undercut this point, for the moment the focus of most refusals has been on actions associated with sexual or reproductive decisions of women.

Actions that have a disparate impact on one class of persons—here, on women—are not necessarily unethically or illegally discriminatory (although they may be in some circumstances). But the disparate impact does raise legitimate questions about the underlying motivations of the actors, and the sufficiency of their justifications. This is especially true when those actions impinge upon protected classes of persons, that is, those whom we have historically disadvantaged in law and practice and for whom court now offer more protection from discriminatory state action. It is also true when those actions impinge upon protected classes of rights, of which reproductive

²⁸ Fenton & Lomasky, *supra* note 24, at 582.

choice is one. Some protections are offered by the courts only in the context of state action, but it is illuminating even in a non-legal and purely ethical context to note the intersection of protected class and protected rights at the center of the category of people and services most typically denied on the basis of a right of conscience. One might ask whether the current debate over refusal clauses would sound any different if it were more baldly framed as the asserted right of health care providers to refuse service to "bad women."

A last major source of argument in favor of the right to exercise conscientious objection is the assertion that in most cases the services requested are not really medical services. Even if there is a duty to provide emergency medical care (and arguably all medical care), services such as abortion, contraception, IVF and sterilization can be viewed as lifestyle services rather than medical services. They do not cure a disease, the argument goes, but rather use drugs and medical techniques to accomplish a lifestyle goal.

Again, the argument has multiple responses. First, medical professionals consider these services, at least in most circumstances, to be an important part of good health care. For example, given that pregnancy is a condition with significant medical consequences and a risk of both morbidity and mortality, contraception constitutes preventive health care. To trivialize these services as "lifestyle" issues is to ignore women's health care needs.

Second, to the extent these may in some circumstances be viewed as choices dictated more by lifestyle than by medical necessity, they are nonetheless choices that are constrained by the state-created limits on consumer access to the products and services needed to accomplish these goals. The situation is not one in which a free market of products, suppliers and buyers seek one another out without constraint. Even beyond the practical constraints of insurance coverage (which often directs patients to a limited range of physicians and pharmacies lest coverage be denied), the very products and services themselves cannot be sold except by those who are members of a special collective, that is, licensed health care providers. To practice medicine or sell prescription drugs without a license is a criminal act throughout the country. If these professionals, who have a state-created and state-maintained collective monopoly on these products and services, will not provide service, the patients have nowhere to turn. Thus, what might otherwise be an issue of lifestyle choices is transformed by state action into an issue of medical choice, in which patient and provider stand not as equals with competing moral compasses but rather as petitioner and grantor in a regulated relationship.

V. AN ALTERNATIVE VIEW OF THE REFUSAL CLAUSE DEBATE: COLLECTIVE DUTIES OF THE PROFESSIONAL COMMUNITY

There is ample precedent for limiting the range of conscientious objection for professionals who operate as state actors. The question arises, then, whether such limitations might appropriately be extended to those who, although private actors, are nonetheless in possession of unique privileges by virtue of state licensing schemes that grant them, as a professional group, a monopoly on a public service.

In *Endres v. Indiana State Police*, for example, the 7th Circuit considered a case arising from a religious objection on the part of a state trooper who claimed that his assignment to work as a Gaming Commission agent—an assignment that would require him to assist in the management of the casino industry—would violate his religious beliefs concerning the immorality of gambling. When his request for

reassignment was refused, he filed an employment discrimination action under Title VII of the Civil Rights Act of 1964, claiming that the state could refuse his request only if it could show that accommodation of his religious practice posed an undue burden on the state police, his employer.²⁹

Judge Easterbrook, writing for court, held that the relevant provision of Title VII did not oblige states "to afford the sort of accommodation that Endres requested..." as, otherwise, "law enforcement personnel [would have] a right to choose which laws they will enforce, and whom they will protect from crime."³⁰ He further wrote:

Many officers have religious scruples about particular activities: to give just a few examples, Baptists oppose liquor as well as gambling, Roman Catholics oppose abortion, Jews and Muslims oppose the consumption of pork, and a few faiths ... include hallucinogenic drugs in their worship and thus oppose legal prohibitions of those drugs. If Endres is right, all of these faiths, and more, must be accommodated by assigning believers to duties compatible with their principles. Does [the Civil Rights Act] require the State Police to assign Unitarians to guard the abortion clinic, Catholics to prevent thefts from liquor stores, and Baptists to investigate claims that supermarkets misweigh bacon and shellfish? Must prostitutes be left exposed to slavery or murder at the hands of pimps because protecting them from crime would encourage them to ply their trade and thus offend almost every religious faith?³¹

This might seem, then, to be limited to a concern about the hardship that accommodations would place upon state agencies. Such a concern would be entirely in keeping with existing federal precedent, such as the 2000 decision in *Shelton v. Univ. of Medicine & Dentistry of N.J.*, where the court found that the civil rights of an employee were not violated when a reasonable accommodation, in the form of a lateral transfer, was effectuated in response to her refusal to participate in providing emergency abortion services in life-threatening situations.³² But the *Endres* opinion went further, stating that accommodation would be unreasonable even in the absence of hardship. Agencies "designed to protect the public from danger may insist that all of their personnel protect all members of the public - that they leave their religious (and other) views behind so that they may serve all without favor on religious grounds."

Of course, the *Endres* case concerned agents of the state, and of what one commentator has called a "paramilitary organization" in need of special restrictions on professional autonomy.³³ But, one commentator notes:

Endres's claim ... reflects currently prevailing views as to the importance of self-realization, the role of religion in self-realization, and the degree to which religious values are commonly thought to be privileged as against other values. Obviously, we are far removed

²⁹ *Endres v. Indiana State Police*, 349 F.3d 922 (7th Cir. 2003) (cert. denied, 541 U.S. 989 (2004)).

³⁰ *Id.* at 925.

³¹ *Id.* at 925.

³² *Shelton v. Univ. of Medicine & Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000).

³³ See Barry Sullivan, *Naked Fitzies and Iron Cages: Individual Values, Professional Virtues, and the Struggle for Public Space*, 78 Tul. L. Rev. 1687, 1709 (2004).

from the time when Justice Holmes could dispose of an analogous claim with the aphorism that someone "may have a constitutional right to talk politics, but [not] to be a policeman," as he did in *McAuliffe v. Mayor of New Bedford*. On the other hand, I would submit that only thirty or forty years ago, most policemen assigned to protect a casino or a barroom would have accepted that as part of their jobs; they would have done it, regardless of their personal, religious views. This is not to say that they took their religious beliefs less seriously, but that they did not think that it was the state's job to design their public responsibilities in a way that accommodated or complemented their personal religious views.³⁴

It is this emerging norm of "self realization" in the professions that is in tension with the fact that some professions operate in a restricted market. The restricted nature of the medical products and services markets functions to create a new relationship between provider and patient. As Fenton and Lomasky put it, in their discussion specifically of pharmacist refusals:

"[T]he salient point is that pharmacist and prospective client do not stand to each other as any two random agents endeavoring to secure their various ends as they make their way through the world. With regard specifically to the liberty to transact in the distribution/procurement of regulated drugs, they do not stand as moral equals. The institutional structure within which pharmacy is practiced has advantaged one party, and that advantage is secured to some extent at the expense of the other. It cannot, therefore, be presumed that the general principle of rejecting coerced cooperation with other persons' endeavors continues to hold. Specifically, ... some limitation of pharmacists' right to choose their clients is justifiable compensation to that clientele for having their own domain of choice limited."³⁵

By analogy, other state-created limitations on product and service sales are accompanied by a restriction on the liberty of the providers. The public utility that sells electricity is not permitted to refuse service to the KKK or to the Planned Parenthood clinic, regardless of the moral and religious views of the management or shareholders. The medallion cabs (that is, the taxis with the exclusive right to pick up hailing passengers from the street) are not permitted to refuse service to women immodestly dressed or men whose clothes denote a particular religious affiliation. (Indeed, in reaction to a growing number of Muslim taxi drivers at the Minneapolis airport refusing to pick up passengers carrying duty-free bags with alcoholic beverages, a new directive was issued forcing them to serve these passengers or pay a fine.³⁶) The prison official who denies emergency contraception to an inmate who was raped is denounced.³⁷ And while the federal public accommodations law, which prohibits discrimination "of

³⁴ *Id.* at 1709-10.

³⁵ Fenton & Lomasky, *supra* note 24, at 585.

³⁶ David Van Biema, *Minnesota's Teetotal Taxis*, TIME MAGAZINE, Jan. 29, 2007, at 30.

³⁷ Editorial, *Jailing Victim is Outrageous*, ST. PETERSBURG TIMES, Jan. 31, 2007, at 10A.

the goods, services, facilities, privileges, advantages and accommodations of any place of public accommodation ... without discrimination or segregation on the ground of race, color, religion, or national origin," does not list "sex" as an impermissible basis for exclusion, it might be argued that it is time to enshrine in law the notion that health care provider institutions should be treated as public accommodations that, at a minimum, do not discriminate directly or indirectly on the basis of sex.

A natural result of such an analysis might well be that, at the very least, a profession in possession of a state-created right to be the sole purveyor of products and services must ensure that every member of the public have non-discriminatory access to its products and services. That is, the profession as a collective unit takes upon itself a collective obligation to the patients it serves. How that obligation is fulfilled may vary from state to state, or profession to profession, provided that the collective obligation is met. In the early era of the AIDS crisis, for example, some HCPs resisted treating HIV-positive patients for fear of becoming infected themselves. Yet as professional groups, HCPs recognized the obligation to provide care. In some settings, the obligation was fulfilled by having only volunteer HCPs treat the infected patients, while other HCPs opted out. In other settings, the obligation to treat was shared by every member of the profession and no opt-out provisions were made. In all cases, though, there was a shared agreement that there was indeed an obligation to provide care, because no other market for care existed outside the profession.

In the context of today's debates, one means of meeting a collective obligation is to require every individual HCP to provide all products and services, thus denying the legitimacy of even the narrowest conscientious refusal laws of the 1970s, which focused almost exclusively on the actual performance of abortions and sterilizations. This could be accomplished at the state level either by establishing such a duty as a condition of licensing, or by enshrining such a duty in state law such that violation rendered the HCP vulnerable to medical malpractice litigation. Another approach would be to modify employment discrimination laws to make it more difficult for employees in health care professions to sustain religious discrimination claims when they are penalized for failing to perform their duties to their patients. Outside of state measures, professional societies can continue to articulate their own ethical standards, and in this way lay the groundwork both for individual HCPs to see their way clear to serving patients even in ways that violate their own preferences and beliefs, as well as to assist courts in determining the customary and standard practice in medical malpractice cases based on refusal of service or medical abandonment.

A less extreme means for achieving a reasonable result for patients is to accept a collective responsibility to make all legal products and services reasonably available. This is the tactic taken by those laws that focus on establishments rather than individual professionals. Thus, such laws may require that all licensed pharmacies have at least one pharmacist on hand during business hours who can fill all prescriptions, without requiring that each and every pharmacist at the establishment actually fill the prescriptions. While potentially burdensome for small pharmacy practices, it is manageable for larger establishments and most chains. (And indeed, many public accommodation laws make some exception for small family-owned businesses where compliance would be unusually burdensome.)

This approach still requires the refusing provider to inform patients of their legal options and to make a referral (or pass along a prescription) where necessary to facilitate the patient's request. For many who assert a right of refusal, such a solution still fails to meet their objection to being made complicit in the patient's choices. This

expanded notion of complicity is consistent with other areas of public discourse, such as bans on federal funding for embryo research or abortion services, in which taxpayers claim a right to avoid supporting objectionable practices. In the debate on refusal clauses, some professionals are now arguing that the right to practice their religion requires that they not be made complicit in any practice to which they object on religious or moral grounds, even if their concerns about complicity do not extend to the situations of criminals (discussed above) nor comport with modern notions of non-discrimination against women.

A less discussed and potentially more thorough alternative is to alter licensing laws in a fashion that would permit pharmacies to join different kinds of guilds, one of which offers all legal services but others of which offer only those services that are consonant with their own particular religious or moral vision. Such a parallel system exists in the world of hospital care, in which Catholic hospitals refuse to provide contraception, sterilization, abortion or in vitro fertilization services. This compromise is highly imperfect—where such hospitals are the only available health care centers in a community, or where hospital and HMO mergers have resulted in extension of such doctrinal restrictions to the secular facilities in the area, the practical result is indistinguishable from a legal prohibition on obtaining these services. Further, as the market for medical care is distinctly different than markets for consumer goods, such market system solutions may leave patients without viable alternatives. For example, even where full-service providers exist in a patient's area, the patient's insurance may restrict coverage in a manner that limits reimbursements to those services offered at the covered institution, thus preventing patients from acting as autonomous agents in a purer market. Nonetheless, such a balkanized version of the health care system could at least provide notice to prospective patients (assuming the notice is prominent and effective), and avoid the creation of reliance interests—a reliance on the pharmacy or health care center to provide requested services—in such a way that at least affords a theoretical possibility that patients could protect themselves by knowing ahead of time that they will need to search farther afield.

More ominously, some establishments are seeking to avoid these battles entirely by simply choosing not to stock the products that are the most contentious. In the most well-known example of this tactic, Wal-Mart made the decision to avoid stocking emergency contraception, thus eliminating the problem of managing individual pharmacist refusals, either by hiring additional pharmacists to provide the service or by forcing all employees to respect patient requests. As described in a 2005 piece from The Guttmacher Report:

The potential reach of this policy, and its impact on women's ability to access emergency contraception in a timely manner, should not be underestimated. For women living in rural areas, Wal-Mart may be the only pharmacy within miles. Moreover, with almost 4,000 locations nationwide, the retailer is a behemoth by industry standards and still growing: A 2003 projection estimated that it would control 25% of the drug store industry by 2007.³⁸

³⁸ Cynthia Dailard, *Beyond the Issue of Pharmacist Refusals: Pharmacies That Won't Sell Emergency Contraception*, GUTTMACHER REP. ON PUB. POL'Y, Aug 2005, at 10.

While Wal-Mart subsequently reversed this policy, it was an object lesson for other businesses that may be considering a wholesale withdrawal from the field of selling contraceptives or providing reproductive care. The reversal of the Wal-Mart policy followed a very vocal public campaign, but smaller businesses—which may nonetheless be significant factors in their local markets—may choose the same strategy, with little risk of generating a national outcry sufficient to trigger a reversal of their policy.

VI. CONCLUSION

The problem of access due to a combination of refusals or the decision not to stock certain products is poorly documented, but reports are slowly emerging. The Washington Post ran a series of articles in July 2006 with personal stories of refusals for services ranging from contraception to artificial insemination. In August 2006, the Associated Press ran a story that read in part:

In complaints filed Monday with the Washington State Board of Pharmacy, the women said they were unable to get a total of 17 prescriptions for Plan B filled in June and July at four stores in the state capital and neighboring Lacey.

One, Stephanie Conrad, said she filed her complaint because of an experience weeks earlier after a condom broke.

"I couldn't find a Plan B pill for 45 hours after. I ended up getting pregnant. Then I had a miscarriage," Conrad said. "It was very painful emotionally and physically. I just wish it could have been avoided."

The complaints show "that there are major access problems in this community," said Janet Blanding, a medical transcriptionist. "These were legal prescriptions given to women of childbearing age."

Samantha Lee Margerum, one of the women, said she was sent from one store to another to another until, nearly an hour after beginning her quest, she was able to get a prescription filled at the fourth store, a Walgreens in west Olympia.³⁹

At the heart of this debate and the growing trend toward countenancing service refusals are several intersecting forces. One is the emerging norm of patient autonomy, which has contributed to the erosion of the professional stature of medicine. Insofar as they are reduced to mere purveyors of medical technology, doctors no longer have extraordinary privileges, and so their notions of extraordinary duty—house calls, midnight duties, and charity care—deteriorate as well. In addition, an emphasis on mutual responsibilities has been gradually supplanted by an emphasis on individual rights. With autonomy and rights as the preeminent social values comes a devaluing of relationships and a diminution of the difference between our personal lives and our professional duties.

Second, there is the ever expanding range of topics linked to the core debate concerning female sexuality and the right to obtain an abortion. Cast as an issue of "right

³⁹ Associated Press, *9 Women Complain Plan B Not at Pharmacies*, Aug. 1, 2006.

to life" rather than equality for women, opposition to abortion has now been linked to topics such as emergency contraception, research involving human embryos, the donation of organs from anencephalic neonates, and the right of persons in a persistent vegetative state to die. While abortion draws the most public attention, the battleground is in fact much larger.

Most profoundly, however, the surge in legislative activity surrounding refusal clauses represents the latest struggle with regard to religion in America. Should the health care marketplace—a part of the public square—be a place for the unfettered expression of religious beliefs, even when such expression causes injury to others, such as patients? Or should it be a place for religious expression only if and when that does not in any way impinge on others? The debate here is part of the debate that has been played out with respect to blue laws, school prayer, Christmas creche scenes, and workplace dress codes. It is, at core, a debate about whether tolerance of individual patients' choices and enhancing a duty of public obligation when engaging in public, professional activities, constitutes an advance in civil society or an unacceptable secularization of what, for many, is or ought to be a religious country.

Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth and undoubtedly many of the health care providers who refuse to treat or refer or inform their patients do so in the sincere belief that it is in the patients' own interests, regardless of how those patients might view the matter themselves. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."⁴⁰

⁴⁰ C. S. Lewis, *GOD IN THE DOCK: ESSAYS ON THEOLOGY AND ETHICS*, 292 (Walter Hooper ed., Wm. B. Eerdmans Publishing Co., 1994) (1970).